

2026-2027 Returning Student Application

This Enrollment Application is only for Students who were enrolled in the Preschool Program at Vivian D. Adams Early Childhood Center or Dr. Katie Harper-Wright during the 2026-2027 academic year. **Note: Additional Documents* may be required to complete the Returning Student Enrollment process - including Birth Certificate, Proof of Residency, Proof of Income, Updated Medical Records, etc.**

Information contained on this form will be kept CONFIDENTIAL. Knowing information regarding your child/family will assist our staff in determining eligibility and priorities for program placement. **Please check the box below to confirm that acknowledge this statement:**

☐ Yes, I acknowledge this statement

(Please Print)

Date: ____/____/____

Child's Full Name (as listed on Birth Certificate): _____

Teacher's Name/Classroom (from previous school year): _____

Name of Person completing this application: _____

Relationship to child:

Mother: ____ Father: ____ Grandparent: ____ Guardian: ____

Foster Parent: ____ Case Manager: ____ Other: _____

What is your current contact information?

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (____) _____ Telephone Number: (____) _____

Email Address: _____

MEDIA RELEASE

Students in School District 189 may be included in photographs, videotaped or recorded interviews, and the information collected by the media to be used as part of news stories to be published in print, internet, broadcast, or video by the school, news media, or School District 189. Images and/or filmed or audio recordings will not be used for commercial gain and will not be sold to anyone for commercial use. **If you DO NOT give School District 189 permission for your child to be photographed or filmed, please complete the statement below.**

As the parent/guardian of _____ who attends _____,
I DO NOT give permission to School District 189 to photograph or videotape my child.

Printed Name of Parent: _____

Signature of Parent: _____ Date: ____/____/____

PARENT/GUARDIAN or OTHER CAREGIVER - 1

Questions in this section relate to the child's PRIMARY caregiver.

Name of Primary Caregiver: _____

Relationship to child:

Mother: _____ Father: _____ Grandparent: _____ Guardian: _____

Foster Parent: _____ Case Manager: _____ Other: _____

Highest Level of Education Completed:

Less than 8th Grade: _____ Some High School: _____ High School Diploma: _____

GED: _____ Some College: _____ Associates Degree: _____

Bachelor's Degree: _____ Graduate Degree: _____ Doctoral Degree: _____

Where do you live with the child?

_____ Primary Residence (Your own home/apartment)

_____ With a relative

_____ In a shelter

_____ Other

Address (if different from the child's address):

Street Address: _____ City: _____ State: _____ Zip: _____

Check All That Apply:

Employed Full Time: _____ Employed Part Time: _____ Active Duty Military: _____

Retired Military: _____ Full-Time Student: _____ Part-Time Student: _____

Unemployed: _____

If employed, occupation: _____ Employer Name: _____

Marital Status: Single: _____ Married: _____ Widow/Widower: _____

Language(s) spoken in the home (Check all that apply): English: _____ Spanish: _____ Other: _____

PARENT/GUARDIAN or OTHER CAREGIVER - 2

Questions in this section relate to the child's SECONDARY caregiver.

If there is a Secondary Parent/Guardian in the home, please provide the Name and Telephone Number for that person:

Name: _____ Telephone: (_____) _____ - _____

If employed, occupation: _____

FAMILY INCOME INFORMATION (REQUIRED)

What is your household income? _____ Monthly: _____ Annually: _____

Total number of individuals residing in the household (including yourself): _____

Do you receive any of the below public benefits or income sources (check all that apply)?

TANF: _____ WIC: _____ Unemployment: _____ SNAP (food stamps): _____

Fixed Income: _____ Private Medical Insurance Assistance: _____ Private Medical Insurance: _____

Child Support: _____ Child Care Assistance (CHASI): _____ SSI for Adults: _____

SSI for child: _____ Medical Card: _____ None of the above: _____

INFORMATION SHARING CONSENT/SCREENING CONSENT

I give consent for electronic transmission/storage of records and for my child to participate in a dental, developmental, vision, and hearing screening administered by Vivian Adams, Katie Wright, and/or the Greater East St. Louis Learning Partnership.

I agree to list child/family information disclosed on the preliminary application, during the family interviews, screening results, weighted eligibility form, supporting documents, and screening data to collaboration partners in order to assist in coordinating and providing the most appropriate services for my child/family.

I understand that I may be contacted by staff from the community partners listed above if more information is needed. I understand that screening results will be discussed with me, including any required referrals that may need to be made for further evaluation as required by the Individuals with Disabilities Act. If referrals are needed, I give my consent to share my child/family information with the programs listed above. This consent is valid for one year from the signature date.

Parent/Guardian Signature: _____ Date: ____/____/____

If there is anyone associated with the above named collaboration partners you do not want us to share information with, list the name below:

Staff Signature (for Office use only): _____

EMERGENCY RECORD & PICK-UP AUTHORIZATION

Child's Name: _____ Address/City: _____

Mother's Name: _____ Address/City: _____

Cell Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

Father's Name: _____

Cell Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

Persons to be contacted in the event of an EMERGENCY when the child's Parent / Guardian cannot be reached:

1. _____
(Name) (Address/ City) (Relationship)

(Cell Phone) (Home Phone) (Work Phone)
2. _____
(Name) (Address/City) (Relationship)

(Cell Phone) (Home Phone) (Work Phone)

PERSONS AUTHORIZED TO PICK UP MY CHILD: Only the people listed below (with a photo I.D.) will be able to pick up your child.

1. Name: _____ Phone: (_____) _____ - _____
2. Name: _____ Phone: (_____) _____ - _____
3. Name: _____ Phone: (_____) _____ - _____
4. Name: _____ Phone: (_____) _____ - _____
5. Name: _____ Phone: (_____) _____ - _____

Is there anyone that your child(ren) SHOULD NOT be picked up by or allowed to see?

1. Name: _____

Is there an order of protection in force against this person? No: _____ Yes: _____
If "YES" provide a copy.
2. Name: _____

Is there an order of protection in force against this person? No: _____ Yes: _____
If "YES" provide a copy.

Parent Guardian Signature: _____ Date: _____ / _____ / _____

(I certify the information provided on this form is true and correct)

CHILD DEVELOPMENT AGREEMENT

Child's Full Name (as listed on Birth Certificate): _____

I CONSENT (1) That my child may participate in all health activities in which immunizations, vision, dental, hearing, physical examinations, lead screening, or treatment are given as part of the school program. (2) That in case of an emergency, I give my permission to the program staff to secure the needed emergency medical care and for the program medical staff to administer emergency medications if the parent/guardian cannot be immediately contacted. (3) To provide the required proof of birth and immunization records on my child. (4) That necessary information concerning my child may be released to other appropriate agencies and that my child's permanent health record may be released to the appropriate schools at the end of this program. (5) That any picture taken of my child may be used for newspapers, displays, bulletin boards, or other types of educational publications. (6) That my child may accompany his/her class on all scheduled field trips, with and/or without parent attendance. When applicable, additional accommodations may be needed. Please refer to the teacher. (7) That my child will attend the program every day that he/she is able. When my child is ill or unable to attend, I will call the program before 9 a.m. (8) To allow staff to make home visits, as required by the program, during the program/school year at my convenience. (9) That at the end of the program day, or during the day, my child may be released to the person(s) whose name and picture ID are listed on the Emergency Record & Pick-Up Authorization form.

I consent: _____ I do not consent: _____ I consent with exception to immunization: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Parent/Guardian Volunteer: I am interested in volunteering:

Yes: _____ No: _____

I will try to attend the program's parent meetings, activities, and parent council workshops:

Yes: _____ No: _____

MEDICAL TREATMENT AUTHORIZATION

Child's Physician: _____ Phone: (_____) _____ - _____

Street Address: _____ City: _____ State: _____ Zip: _____
(If the child does NOT have a regular physician, write "None")

Is your child currently using medication? If "Yes," list the medications in the space provided.

☐ Yes _____

☐ No

Does your child have any allergies to food, medication, or other irritants? If "Yes," please explain in the space provided.

☐ Yes _____

☐ No

Does your child have a restricted diet? If "Yes," please explain in the space provided.

☐ Yes _____

☐ No

Please check the space for any Services you DO NOT wish your child to receive (check all that apply):

First Aid Treatment: _____ Dental Care: _____ School Physical/Sports Physical: _____

Examination/Treatment for Complaints of Illness: _____ Immunization/Well Child Visit: _____

Medically Prescribed Laboratory Tests: _____ Preventative Health Education Services: _____

Health Education & Counseling (Nutrition, Fitness, Hygiene, Self-Esteem): _____

Medical and Social Referrals: _____

MEDICAL REQUIREMENT

Please provide us with an updated copy of your child's immunization/shot records each time your child receives a Well Child Visit. Any child who is required to have medication administered during the school day (i.e., asthma, allergy) and/or prescribed must have an Action Plan (Asthma), Allergy Plan (food EpiPen), and medical authorization signed on an Illinois release form by the physician, along with the medication in the original box returned to the school nurse.

_____ **I acknowledge the Medical Requirement statement above.**

I authorize School District 189, Vivian D. Adams Early Childhood Center, and Dr. Katie Harper-Wright Elementary School staff to take whatever emergency medical measures are deemed necessary for the protection of my child while he/she is in their care. I understand that this authorization includes calling the physician named above, implementing his/her instructions, and transporting my child to a hospital or clinic without first obtaining my consent.

Parent/Guardian Signature: _____ **Date:** _____ / _____ / _____

PFAE FAMILY & INDIVIDUAL INTEREST SURVEY

2026-2027 RETURNING STUDENT APPLICATION

I would like to get more information about the following topic(s):

____ Health & Wellness	____ Discussion Group/Advocacy
____ Kindergarten Readiness	____ Creative Arts/Literacy
____ Employment Readiness	____ Parent-Only Field Trips & Activities
____ Family Support Services	Other _____

FAMILY PARTNERSHIP AGREEMENT

Through the Family Partnership Agreement, the Family & Parent Engagement Team helps families work towards a goal they've selected for the school year. The selected goal can be for the Parent / Guardian, the Family, or for the child enrolled in the preschool program. This school year, I would like to:

____ Continue My Education	____ Rebuild My Credit Score
____ Start a New Job	____ Help Prepare My Child for Kindergarten
____ Start My Own Business	____ Become a Better Advocate for My Child
____ Move Into a New Home/Apartment	Other _____

FAMILY NEEDS ASSESSMENT

The topics in this section help us determine whether or not there are any individual or family concerns that require immediate attention. Please be as honest as possible and circle the most accurate number.

Scoring Legend: 1 = Need Assistance 2 = Making Progress 3 = Strength

Safety (from crime or abuse): 1 2 3	Job training and career goals: 1 2 3
Employment (information, resume writing, etc.) 1 2 3	Have plans in place for Kindergarten transition: 1 2 3
Using positive parenting practices: 1 2 3	Understand social-emotional impact of school transition: 1 2 3
Overcoming my child's behavioral challenges: 1 2 3	Building a support system (family, social services): 1 2 3
Partnering with the school to support my child's learning: 1 2 3	Volunteer in school or community organization: 1 2 3
Communicating with my child's teacher: 1 2 3	Involvement in my child's education: 1 2 3
Continuing my education: 1 2 3	Awareness of State/Federal issues that affect young children and their families: 1 2 3

The Family Partnership Agreement was explained to me, and I am willing to participate in this agreement at this time. This tool will be used as we partner together to identify and work towards my goal. Information shared with East St. Louis School District 189 staff will be kept confidential unless a release form is signed by the Parent/Guardian listed below or a legal representative of the family.

Parent/Guardian Signature: _____ Date: ____/____/____

Staff Signature: _____ Date: ____/____/____

Home Language Survey

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

1. Is a language other than English spoken in your home?

Yes _____ No _____

Which language? _____

2. Does your child speak a language other than English?

Yes _____ No _____

Which language? _____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

Parent/Legal Guardian Signature

Date

JOINT NOTICE OF PRIVACY PRACTICE / EAST SIDE HEALTH DISTRICT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

East Side Health District (ESHD) works with other practitioners in delivering services to you. The practitioners include doctors, contractors, and other healthcare professionals who are not part of the ESHD's workforce. All of these practitioners will follow this Joint Notice of Privacy Practices in delivering service to you.

The ESHD and the practitioners involved in your care create a medical record of your health information in order to treat you, receive payment for services delivered, and comply with certain policies and laws. The uses and disclosures described in this Notice are applicable to the health department and all of the practitioners (collectively "we") who are part of this Joint Notice of Privacy Practices while they are delivering services at a health department facility or on behalf of the health department. This Joint Notice does not apply to service providers who are not part of the health department when they deliver services elsewhere or only on their own behalf.

We are required by federal and state law to maintain the privacy of your PHI. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

THIS IS A LIST OF SOME OF THE TYPES OF USES AND DISCLOSURES OF PHI THAT MAY OCCUR:

Treatment: We obtain medical information about you in treating you. This medical information is called "protected health information" or "PHI". Your PHI is used by us to treat you. For example, we refer to PHI in treating you at the health department. We may also send your PHI to another physician or counselor to which we refer you for treatment. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our clients. From time to time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons: **Public Health:** We may use and disclose your health care information to prevent or control disease, injury, or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate the delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to disclosure of your PHI by the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt. **Immunizations:** We may release information regarding immunizations to a school or other facility with your permission.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for the proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials.

We may use or disclose PHI for the conduct of national intelligence activities. **Correctional institutions and custodial situations:** We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclose PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: If we undertake any fundraising activities, we may contact you about the fundraising activity. You may opt out of receiving fundraising information. Instructions to do so will be provided if you request to opt out.

Marketing: We do not typically engage in marketing activities, and would need your authorization to do so.

Sale of PHI: We will not sell your PHI without your authorization.

ILLINOIS LAW: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

YOUR RIGHTS: You have certain rights under federal privacy laws relating to your PHI. Some of these rights are described below: **Restrictions:** You have a right to request restrictions on how your PHI is used for purposes of treatment, payment, and healthcare operations.

We are not required to agree to your request. We will agree to your restriction if you request that we do not bill your health plan and you have paid for your services in full in advance.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, we will accommodate it.

Inspect and Access: You have a right to inspect information used to make decisions about your care. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options. You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Breach: If there is a breach affecting your unsecured PHI, we will notify you.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at the health department offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with the health department by calling our Privacy Officer at 618-874-4713. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

We maintain a facility directory so that if family or friends ask us about your condition, we can tell them general information and the fact that you are here. If you do not want us to tell anyone you are here, please tell us now.

We are required to abide by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at www.eshd.org or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

EFFECTIVE DATE: September 23, 2013

East Side Health District
650 N. 20th Street, East St. Louis, IL 62205
Ph: (618) 874-4713
Fax: (618) 874-4737

CONSENT TO ENROLL

I hereby consent to the enrollment of myself / child in the School-Based Health Center, and to medical treatment encompassing routine diagnostic treatment and medical treatment by the medical staff of their designees as deemed necessary in their judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination. I acknowledge the receipt of the Notice of Privacy Act dated September 23, 2013, and give consent for the release of necessary information to the school districts for the purpose of documenting compliance with state requirements of physicals and immunizations. I authorize the payment of medical benefits to the East Side Health District and the release of PHI necessary to process this claim. A photocopy of this authorization is considered as an original. I certify that the above information is correct to the best of my knowledge.

I have reviewed the comprehensive health services listed on this form, and have written NO for any services that I do not wish my child to receive. Yes: _____ No: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Health Center Staff: _____ Date: ____/____/____
(For office use only)